

South Carolina Department of Social Services  
**FAMILY INDEPENDENCE HEARING QUESTIONNAIRE**

Name: \_\_\_\_\_

Check Yes, No or Sometimes in response to each question. If you do not engage in a particular activity, respond according to the way you feel you would respond in that situation.

1. Does a hearing problem cause you to feel embarrassed when you meet new people?  
☐ Yes   ☐ No   ☐ Sometimes
2. Does a hearing problem cause you to feel frustrated when talking to your friends and family?  
☐ Yes   ☐ No   ☐ Sometimes
3. Do you have difficulty hearing or understanding co-workers, clients or customers?  
☐ Yes   ☐ No   ☐ Sometimes
4. Do you feel that you have a hearing problem?  
☐ Yes   ☐ No   ☐ Sometimes
5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?  
☐ Yes   ☐ No   ☐ Sometimes
6. Does a hearing problem cause you difficulty in the movies or in the theater?  
☐ Yes   ☐ No   ☐ Sometimes
7. Does a hearing problem cause you to have arguments with family members?  
☐ Yes   ☐ No   ☐ Sometimes
8. Does a hearing problem cause you difficulty when listening to TV or radio?  
☐ Yes   ☐ No   ☐ Sometimes
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?  
☐ Yes   ☐ No   ☐ Sometimes
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?  
☐ Yes   ☐ No   ☐ Sometimes

If you answered Yes to five or more questions, you may want to discuss having your hearing tested with your physician.

## INSTRUCTIONS FOR DSS FORM 1321

**Purpose:**

This form is used as a screening tool during the client assessment process. The FI participant should complete the questionnaire. The CM should file the form in the participant's case management file.